

## Disclosure & Barring Service Check Application

Surname:		Forenames:		Middle Name:	
Title:		Date of Birth:		Previous Names: Year from:                      to:	
Marital Status:		Date of Marriage:		Maiden Name:	
Town/City of Birth:		Country of Birth:		National Insurance Number:	
Current Nationality:	Nationality at Birth:	Passport No:	Visa details (if applicable):		Expiry date:
Birth Certificate No:			Home Office Letter Ref:		
Are you currently subject to any criminal proceedings, convictions or cautions:    Yes            No					
If yes, please specify:					

You must provide all the addresses where you have lived in the last 5 years. There must be no gaps in dates, however overlapping dates are acceptable. **All fields must be completed for each address**

<b>Current Address:</b>	
_____	
_____	
Town/City:	County:
Post Code:	Country:
From:	To:

<b>Previous Address:</b>	
_____	
_____	
Town/City:	County:
Post Code:	Country:
From:	To:

<b>Previous Address:</b>	
_____	
_____	
Town/City:	County:
Post Code:	Country:
From:	To:

<b>Previous Address:</b>	
_____	
_____	
Town/City:	County:
Post Code:	Country:
From:	To:

The Care Standards Act 2000 requires that a check be made on you with the Disclosure & Barring Service. Failure to agree to apply for a disclosure to the Disclosure & Barring Service will result in Proxycare being unable to accept your application. I confirm that the above information is true and I agree for Proxycare to apply for a DBS Check on my behalf using the above information. I consent to share the details of the DBS check with the third party in order to secure work on my behalf.

<b>Print Name:</b>	<b>Signed:</b>	<b>Date:</b>
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**OCCUPATIONAL HEALTH MEDICAL QUESTIONNAIRE  
(NEW STARTER CLINICAL FORM)**

**CONFIDENTIAL**

Due to the nature of the role you have applied for we need to carry out a complete a new starter health questionnaire – even if you have been employed in UK health services before. The health of each candidate is considered individually and a decision regarding fitness for work in the prospective job role will be based on the functional effects of any underlying health condition/disability/impairment as well as health service requirements for fitness and immune status.

Before health clearance is given for employment you may be contacted by Healthier Business UK Ltd and may need to be seen by an occupational health advisor or physician with gained consent. We may recommend adjustments or assistance following an assessment to enable you to carry out your proposed duties safely and effectively. Recommendations to your employer will be directed to essential information regarding your health and the hazards and risks of your employment and with due reference to other relevant statutory requirements and professional practice. Our aim is to promote and maintain the health of all individuals in the workplace: staff, service users and third parties.

Personal Information			
Title	Surname	First names	DOB
Home Tel:	Work Tel:	Mobile:	
Home Address:		GP Address:	

Medical History		
All staff groups complete this section		
	Yes	No
Do you have any illness/impairment/disability (physical or psychological) which may affect your work?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any illness/impairment/disability which may have been caused or made worse by your work?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having, or waiting for treatment (including medication) or investigations at present?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you may need any adjustments or assistance to help you to do the job?	<input type="checkbox"/>	<input type="checkbox"/>

Medical History (continued)			
Have you suffered from any of the following?	Yes	No	Date
methicillin resistant staphylococcus aureus (MRSA)	<input type="checkbox"/>	<input type="checkbox"/>	
clostridium difficile (C-Diff)	<input type="checkbox"/>	<input type="checkbox"/>	

**If you have indicated yes to any of the above questions you must provide further details in additional information section, failure to do so will result in the form being returned/rejected.**

Additional Information
(If you have answered yes to any questions above please provide additional information below, including dates, treatment and details of condition)

Chicken Pox or Shingles			
Have you ever had chicken pox or shingles	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date:

BBV (Blood Borne Virus)		
Have you ever come into contact with any BBV's? Including Needle Stick Injuries?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Tuberculosis		
Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2016)	Yes	No
Have you lived outside the UK or had an extended holiday outside the UK in the last year?	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered YES to the above, please list all the countries that you have lived in/visited over the last year, including holidays and vacations. This MUST include duration of stay and dates or this form will be rejected.**

Have you had a BCG vaccination in relation to Tuberculosis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If you answered yes, please state when;	Date:	

### Tuberculosis Continued

Do you have any of the following	Yes	No
A cough which has lasted for more than 3 weeks	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained fever	<input type="checkbox"/>	<input type="checkbox"/>
Have you had tuberculosis (TB) or been in recent contact with open TB	<input type="checkbox"/>	<input type="checkbox"/>

### Additional Information

(If you have answered yes to any questions above please provide additional information below)

### Immunisation History

Have you had any of the following immunisations	Yes	No	Date
Triple vaccination as a child (Diphtheria / Tetanus / Whooping cough)	<input type="checkbox"/>	<input type="checkbox"/>	
Polio	<input type="checkbox"/>	<input type="checkbox"/>	
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B (If Yes is ticked please give dates below)	<input type="checkbox"/>	<input type="checkbox"/>	
Course:	1	2	3
Boosters:	1	2	3

### Proof of Immunity (Please send the following)

<b>Varicella</b>	You must provide a written statement to confirm that you have had chicken pox or shingles however we <b>strongly advise</b> that you provide serology test result showing varicella immunity
<b>Tuberculosis</b>	We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result <b>(Do not Self Declare)</b>
<b>Rubella, Measles &amp; Mumps</b>	Certificate of <b>"two"</b> MMR vaccinations or proof of a positive antibody for Rubella and Measles
<b>Hepatitis B</b>	You must provide a copy of the most recent pathology report showing titre levels of 100IU/l or above

### Proof of Immunity (Please send the following) EPP Candidates Only

<b>Hepatitis B Surface Antigen</b>	Evidence of Hepatitis B Surface Antigen Test (Inc. 'e' antigen and DNA viral loads if applicable) Report must be an identified validated sample. (IVS)
<b>Hepatitis C</b>	Evidence of a Hepatitis C antibody test (Inc. Hepatitis C RNA/PCR if applicable) Reports must be an identified validated sample. (IVS)
<b>HIV</b>	Evidence of a HIV I and II antibody test (Inc. DNA viral loads if applicable) Reports must be an identified validated sample. (IVS)

### Exposure Prone Procedures

Will your role involve Exposure Prone Procedures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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### The General Data Protection Regulation (GDPR) (EU) 2016/679

All information supplied by you will be held in confidence by Healthier Business UK Ltd. Records will be retained electronically in accordance with best practice and the requirements of the General Data Protection Regulations at which time it may be subject to audit. Your data may also be cross referenced should you have registered with other clients of Healthier Business UK Ltd. Your personal data may be required to be seen by an occupational health advisor or physician, however it will not be shown, nor their contents shared with anyone - including Managers, Human Resources Advisors, GP, Specialist's or third party's - without your explicit consent. You have the right of erasure (the right to be forgotten), withdrawal of consent and refusal of consent without detriment. The only exceptions to this may be a court order for release of records in a judicial dispute or where there is a public responsibility obligation.

### Recommendations

I understand that following this assessment, recommendations may be provided to assist my health at work;		
I give consent for the Healthier Business UK Ltd to make recommendations and for my employer/agency to provide these recommendations to my placement		<input type="checkbox"/>
I would like to see a written copy of any recommendations Healthier Business UK Ltd may make before my employer/agency provide them to my placement		<input type="checkbox"/>

### Declaration

I will inform my employer if I am planning to or leave the UK for longer than a three-month period to enable a reassessment of my health to be conducted on my return.

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief.

Name	Signature	Date